COMMANDERS DIGEST

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DoD'S REVISED CHAMPUS PROGRAM

Beginning in 1961, large numbers of military personnel who began their military careers during World War II became eligible for retirement by virtue of completing 20 years of active military service. In 1962, the impact of the retirement problem on the military health care system became a matter of concern within the Department of Defense. Early in 1963, the Secretary of Defense established a study group to look into the health care aspects of the retirement problem.

Early in 1964, concern within the House Armed Services Committee for this problem led the chairman to appoint a special subcommittee chaired by the late L. Mendel Rivers to review the matter. The Rivers Subcommittee considered the report made to the Secretary of Defense by the DoD study group in developing its own recommendations. Both groups advocated the establishment of a civilian health care program for retired members and their dependents since it was clear that in a matter of a few years the health care needs of the retired military population could no longer be met entirely by military medical facilities.

In 1965, the Department of Defense forwarded proposed legislation to the Congress recommending, in effect, that retired members and their dependents be added to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) program. Our proposal, with some modifications, was enacted in 1966. There was a general feeling at the time that an equitable solution to the retired health care problem had been reached. Some doubt has arisen on this question within the past year, however, as there has been an increasing number of instances when retired members and their dependents who had been obtaining their care in military facilities found it necessary to use the 1966 "solution" by obtaining care under CHAMPUS. Many retired members and the associations of other retired personnel to which they belong now feel that cost-shared benefits under the CHAMPUS are not an appropriate substitute for the care at no cost, or in some cases nominal cost, that they had been led to believe they would be entitled to following retirement. The cost-sharing arrangements prescribed by the CHAMPUS law to which they object are:

- For outpatient care, the retired member and his dependents must pay an annual deductible of $50 if benefits are being claimed for only one family member or $100 if benefits are being claimed for two or more family members. Once the annual deductible has been met, the government pays 75 percent of the remaining outpatient charges for the year and the individual pays the remaining 25 percent.
- For inpatient care there are no deductibles. The Government pays 75 percent of the total charges and the individual pays 25 percent.

Cutbacks in retired health care in some military facilities result from a shortage of 1,800 military physicians. The new medical pay bonus law and certain other improvements are expected to make up the physician shortages during Fiscal Year 1976.

The retired health care workload has increased dramatically in the past decade. In 1965 on an average day, there were 3,594 beds in military hospitals occupied by retired members and their dependents and that group made 2.7 million outpatient visits to such facilities in that year. Since they were not covered under the CHAMPUS in 1965, those figures represent the total workload generated by the retired group. Ten years later in Fiscal Year 1974, on an average day, the retired group occupied 9,109 beds and made almost 10 million outpatient visits. Of the occupied beds, approximately 4,600 were in military facilities and approximately 4,400 were in civilian facilities under the CHAMPUS. Of the outpatient visits, 8 million were in military facilities and 1.2 million were obtained under CHAMPUS.

Frequently overlooked by the retired group is the fact that the law governing these matters in effect prescribes a priority system for the care in military facilities which places two groups ahead of them; first, active duty members, and second, the dependents and survivors of active duty members.

The cutbacks in retired health care that have occurred in certain military facilities result primarily from the fact that we are now short approximately 1,800 military physicians. It is our hope that through the new medical pay bonus law and certain other improvements that we are making within our health care system, we will be able to make up our present shortages of physicians during Fiscal Year 1976, and thus be in a position to restore retired health care in military facilities to the levels that prevailed in Fiscal Year 1974.

CHAMPUS

The Civilian Health and Medical Program of the Uniformed Services is a program which provides financial

CHAMPUS TODAY

By
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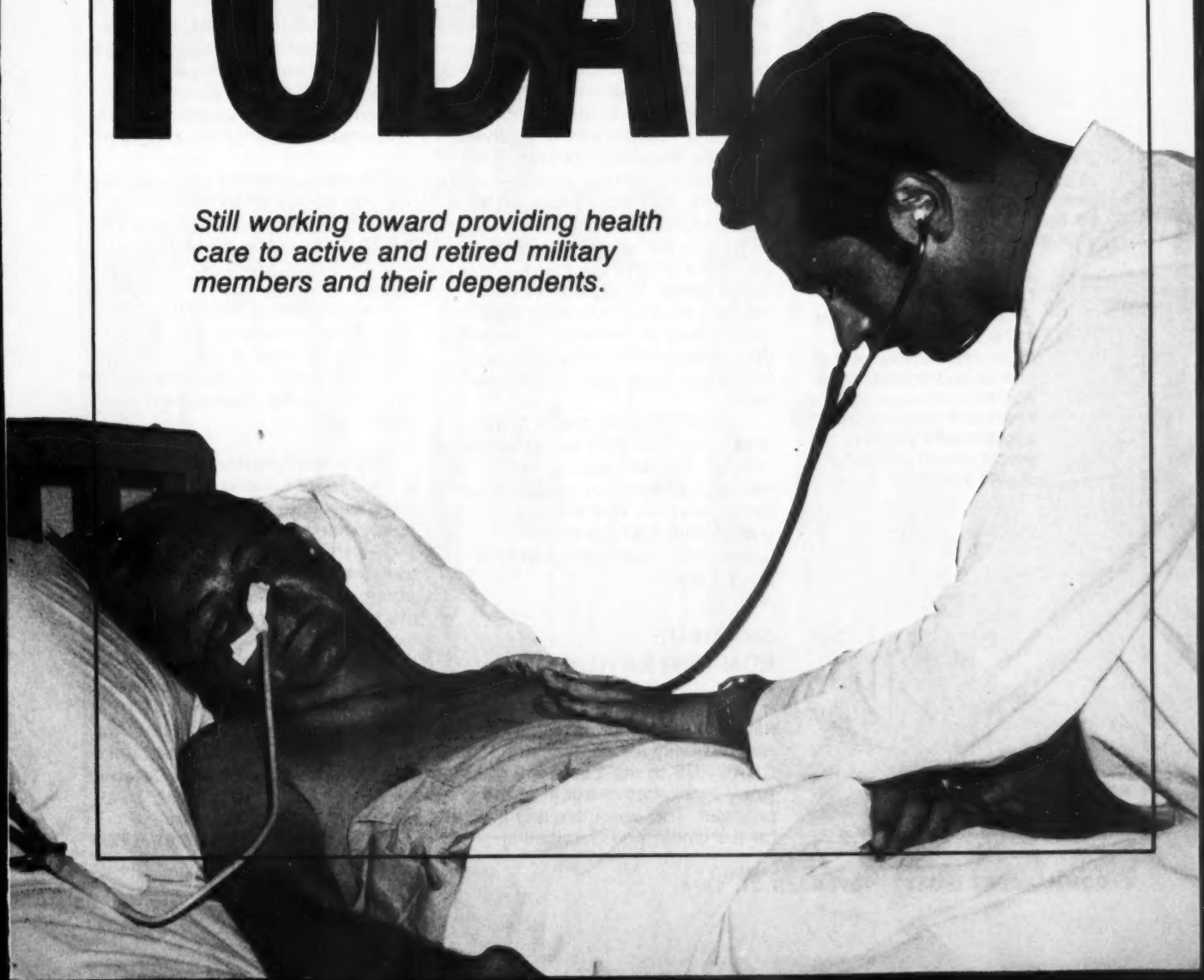
Still working toward providing health care to active and retired military members and their dependents.



In 1972 the responsibility for CHAMPUS was consolidated under the Assistant Secretary of Defense (Health and Environment) for the 50 States, Mexico, Canada, and Puerto Rico. The operation of CHAMPUS in areas overseas remained under the jurisdiction of the Surgeons General of three Services.

VERNON McKENZIE

Vernon McKenzie has served as Principal Deputy Assistant Secretary of Defense (Health and Environment) since August, 1974. His responsibilities involve the development of policies and legislation concerning the operations of health care programs covering approximately 10 million people with an annual budget of over $3 billion.

assistance to its beneficiaries to pay for medical care obtained from civilian sources generally when such care is not available from Uniformed Services medical resources.

CHAMPUS was intended to assure that medical care is available for spouses and children of members of the Uniformed Services, a member or former member who is entitled to retired or retainer pay, or equivalent pay; dependents of a member or former member who is or was at the time of death entitled to retired or retainer pay or equivalent pay; and dependents of members of a Uniformed Service who died while on active duty for a period of 30 or more days.

Prior to the enactment of Public Law 89–614 (the original Dependents' Medical Care Act), medical care for this large group of people was by and large provided by the Uniformed Services medical resources on a "space available" basis.

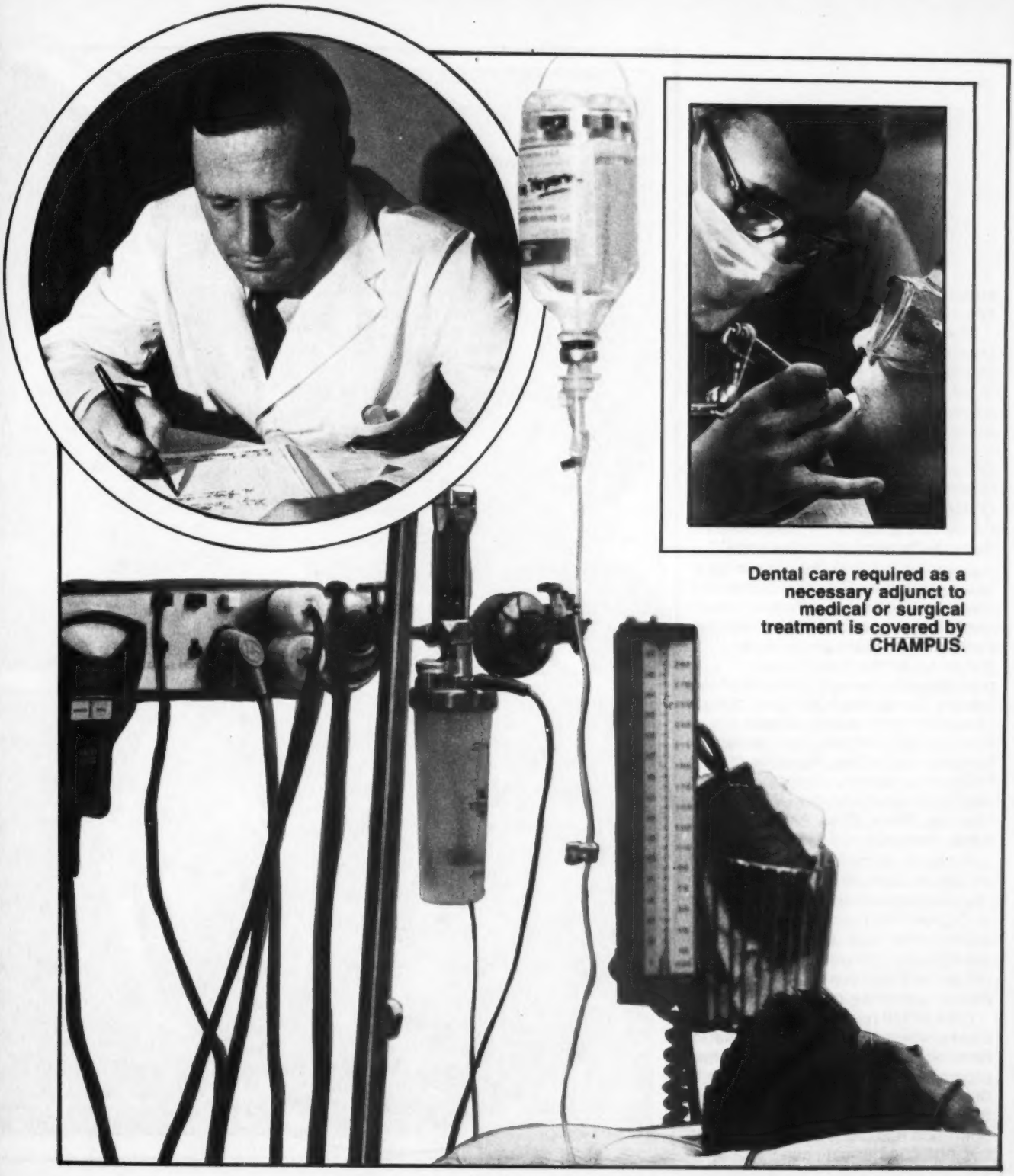
CHAMPUS grew out of numerous pressures. The increasing number of retirees, the decreasing military medical resources available to care for dependents and retirees, and the competition from parallel government health programs all played a part.

CHAMPUS ADMINISTRATION

The administrative structure established in 1956 assigned the responsibility for administering CHAMPUS to the Secretary of the Army as executive agent of the program. The executive agent acted for the Uniformed Services in negotiating and administering contracts for medical and hospital services under policy guidance of the Department of Defense. The Surgeon General of the Army was redelegated the authority and responsibility from the Secretary of the Army to administer CHAMPUS. The Surgeon General of the Army then organized the Office for the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) and appointed an executive director who acted as the line administrator of the program.

The executive director supervised the day-to-day administration of CHAMPUS, negotiating contracts with the fiscal agents, regulating the administrative practices of these agents, and passed recommendations for regulatory or legislative change up through the Surgeon General of the Army, the Army Chief of Staff, the Secretary of the Army, to the Department of Defense.

This administrative structure proved to be cumbersome. Policy decisions were not implemented in a timely manner and, on occasion, lost their original intent as they were transmitted through the intermediate agencies. In order to bring management control of the program closer to the immediate direction of the Secretary of Defense, the executive agent arrangement was discontinued effective July 1, 1972. On that date, responsibility for the CHAMPUS was consolidated under the Assistant Secretary of Defense for Health and Environment. This change affected that part of CHAMPUS which included the 50



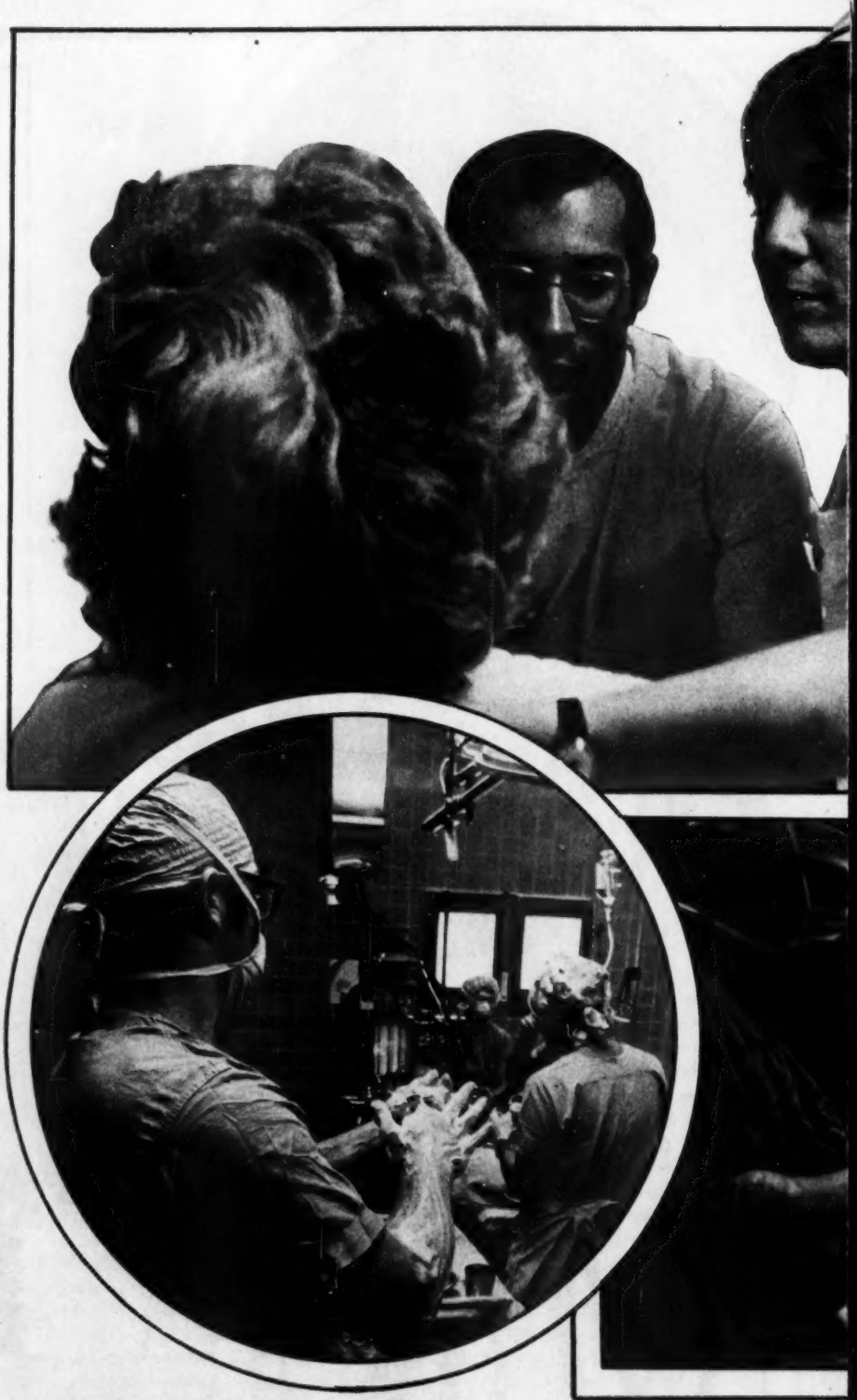
Dental care required as a necessary adjunct to medical or surgical treatment is covered by CHAMPUS.

states, Mexico, Canada, and Puerto Rico.

Operation of CHAMPUS in areas overseas remained under the jurisdiction of the Surgeons General of the three Services. Claims originating in countries in Europe, Africa, and the Middle East are adjudicated and paid by OCHAMPUSEUR, U.S. Army Medical Command, Heidelberg. OCHAMPUSEUR processes claims for beneficiaries of all Uniformed Services located in its assigned geographic area. In the remaining overseas areas, CHAMPUS claims are processed by an office designated by each Military Service. For example, claims from Army personnel in the Pacific are processed by the U.S. Army Medical Center, Camp Kue, Okinawa; Navy personnel send their claims to the Commanding Officer, U.S. Naval Hospital, Subic Bay, Republic of the Philippines; and Air Force personnel send their claims to the USAF Hospital, Clark, Clark Air Force Base, Republic of the Philippines.

A plan to place OCHAMPUSEUR along with its functions and responsibilities under the jurisdiction of OCHAMPUS is currently being staffed within DoD. Plans include establishing OCHAMPUS field offices in South America and the Pacific within the next six months.

CHAMPUS operation within the 50 states, Mexico, Canada, and Puerto Rico represents the major cost of the program. The budget for 1975 for that portion of the program is $501,800,000. The overseas operation has been under $10,000,000.



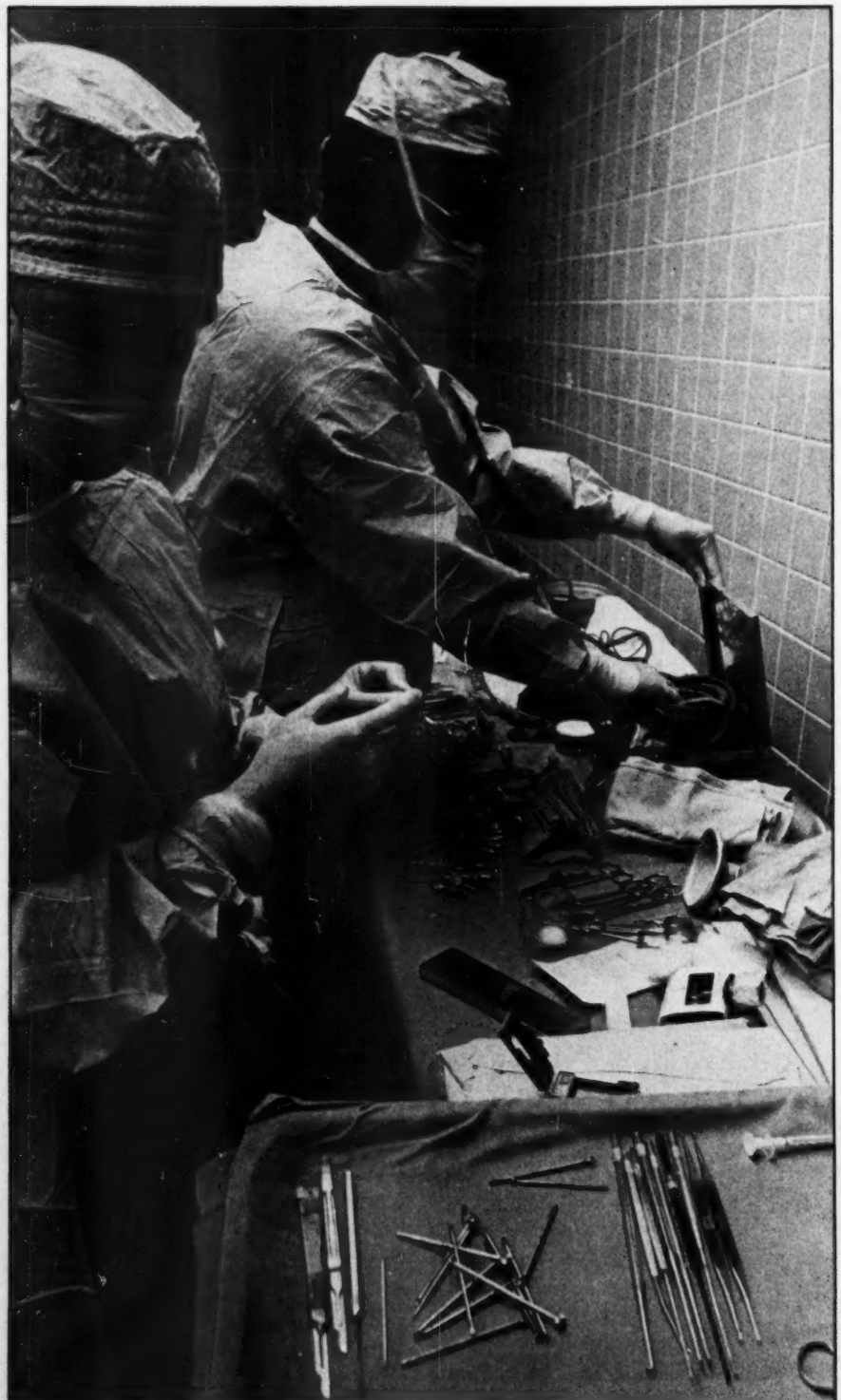
CHAMPUS beneficiaries are not required to pre-enroll or pay any form of dues or premiums. They are eligible for coverage by virtue of their status under the law.

CHAMPUS in the United States, Mexico, Canada, and Puerto Rico is operated through contractual arrangements with private contractors or "fiscal agents" that adjudicate and reimburse for nonhospital medical care under CHAMPUS. Three contracts are with private insurance companies, five are with state medical associations or societies, and the remaining 37 are with Blue Shield Plans.

Claims arising from hospital care are processed by two prime contractors: The National Blue Cross Association and the Mutual of Omaha Insurance Company. Mutual of Omaha covers 17 states, Mexico, and Canada. The Blue Cross Association subcontracts with 34 state Blue Cross Plans and the Blue Cross Plan of Puerto Rico.

The contractors are reimbursed for the administrative costs related to CHAMPUS claims. Reimbursement to the contractors is on the basis of the administrative cost per claim processed. The cost per claim varies from program to program depending upon variables such as volume of claims processed, whether claims processing is manual or computerized, etc. The administrative costs of the program have been running about four percent of total program expenditures.

CHAMPUS beneficiaries are not required to preenroll or pay any form of dues or premiums. They are eligible for coverage by virtue of their status under the law. Use is made of the program when an eligible beneficiary has incurred an expense



Medical services may be provided by a civilian physician or other medically related specialists as ordered by a physician. Authorized services of optometrists and psychologists may be provided without a physician's order.

arising from medical care or treatment. The individual can obtain CHAMPUS assistance in one of two ways:

- He assumes responsibility for the entire bill himself and then prepares and submits a claim to the appropriate contractor's office requesting reimbursement for the CHAMPUS share, or
- He determines if the provider of care will "participate" in CHAMPUS and submit a claim directly to CHAMPUS. "Participation" on the part of the provider is entirely voluntary. Participation means that the provider agrees to accept that amount determined by the Government to be the usual, customary and reasonable fee for the services provided.

While beneficiaries do not pay premiums, they are required by law to share in the cost of the care. In the case of inpatient care for dependents of active duty members, this is $25.00 per admission or $3.50 per inpatient day, whichever amount is greater. All other beneficiaries are responsible for 25 per cent of the reasonable charges. In the case of outpatient care, there is a $50 deductible per fiscal year not to exceed $100 per family. After the deductible has been met, dependents of active duty members cost-share 20 per cent of the remaining reasonable charges. All others cost-share 25 per cent of the remaining reasonable charges.

A significant problem for both beneficiary and the contractor is the claim form. Since there is no

enrollment, each claimant must prove his eligibility each time he files a claim by furnishing certain personal data. Incomplete or inaccurately prepared claim forms result in delays in settling the claims. Each month approximately 14 per cent of the claims are rejected and 11 per cent are returned to the claimant for correction or additional information. In July 1974, there were 336,000 claims filed, of which 79,000 were either rejected or returned. These claim rejections and returns add to both beneficiary dissatisfaction and program administrative costs. We continue to seek ways to inform and educate both beneficiaries and providers of care on the operation of the program.

RECENT CHAMPUS CHANGES

The cost of CHAMPUS has increased each year since 1966. In Fiscal Year 1968, the first year of operation under the 1966 Amendments, the total cost was $166.2 million. The budget estimate for Fiscal Year 1975 was $509.6 million, an increase of over 300 per cent. The increased costs of the program have been a matter of concern to the House Appropriations Committee (HAC) for the past six years. On October 6, 1969, the chairman of the HAC requested the Comptroller General of the United States to make a comprehensive review of the program because " . . . it appears that cost increases are greater than might be expected and not in proportion to benefits derived."

The first report of the General Accounting Office was issued July 19, 1971. Effective response to these reports was hampered by the cumbersome managerial control over the program that existed at the time. As mentioned earlier, the management of the program was consolidated under the Assistant Secretary of Defense (Health and Environment) [ASD (H&E)] effective July 1, 1972. A CHAMPUS policy office under the ASD (H&E) was established as a result of this action. As soon as a staff was assembled, they began a review of the program operations to ascertain specific causes of increased program costs.

Early in this review, it became apparent that significant cost increases were due to the inclusion of benefits that may not have been in the original intent of Congress.

ORTHODONTIA

Orthodontia was the first such "benefit" identified. Orthodontia is a dental specialty which deals with the development, prevention and correction of irregularities of the teeth and malocclusion. Dental care under the CHAMPUS Basic Program is restricted to " . . . only that care required as a necessary adjunct to medical or surgical treatment." Therefore, orthodontia became a coverable benefit under the provisions which established a program for the mentally and physically handicapped. The assumption at the time was that irregularities of the teeth constituted a physical handicap. The law required that a beneficiary have a serious physical handicap to qualify for benefits under the Program for the Handicapped. In our opinion, the use of "serious physical handicap" in the law was intended to convey the concept that qualifying for benefits under the Program for the Handicapped required a confirmed medical diagnosis of disease, injury or other impairment of such a severity as to make a person substantially incapable of engaging in the usual and customary or normal activities expected of unimpaired persons in the same age group. The vast majority of cases being approved for orthodontia did not meet this test and, in fact, were receiving orthodontia primarily for cosmetic purposes. We, therefore, issued more restrictive qualifying criteria, effective July 15, 1973. Prior to this change, claims for orthodontia care were averaging 18,564 per month and new cases being approved for care averaged 2,250 per month. As of May 1974, monthly claims were down to 7,574 and new cases were 353 per month.

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CHAMPUS expenditures were reduced from $1,757,250 per month to under $500,000 per month.

After further review of orthodontia, it was decided to eliminate it as a benefit under the Program for the Handicapped entirely, effective September 1,1974. After that date, orthodontic treatment to be approved under CHAMPUS must meet the requirements of the adjunctive dental care rule of the Basic Program.

It may be well to clarify dental care under CHAMPUS at this point. Adjunctive dental care is that dental care required to eliminate dental disease as a necessary adjunct to the treatment of a primary medical or surgical condition other than dental, wherein proper medical management requires treatment of the dental disease. This area is a difficult one to define and over the past seven years, there has been a significant increase in expenditures for adjunctive dental care. It has risen from a little over $500,000 in 1968 to over $5,000,000 in 1975. We plan to better define and proscribe this area in the near future.

SPECIAL EDUCATION

A second benefit that was permitted to slip in under the CHAMPUS umbrella was special education. The 1966 amendments included an authorization to cover treatment of nervous, mental and chronic conditions. In the course of applying this authorization, lacking more definitive guidlines, program managers permitted the coverage of special educational services for beneficiaries suffering from any of a variety of "educational or learning disabilities." There is no doubt that the needs of our beneficiaries extend beyond what may be defined as medical or health care, or psychiatric or mental care. They also have many social and educational needs. Frequently, the ultimate success of treatment of a physical or mental disorder may depend on social service and educational needs being met concurrently.

It was our conclusion, however, that CHAMPUS was intended to cover only those needs clearly a part of medical care and that special education could not be a benefit under the Basic Program even when it was prescribed or concurred in by a physician. Once this conclusion was reached, we directed that payment of all educational services on an outpatient basis be terminated as of August 31, 1974. To place this decision in proper context, it should be pointed out that education in the United States is the responsibility of the individual states. The "right to education" movement has, in recent years, resulted in significant legislation at the state level mandating special education for all exceptional children. At the present time, 48 of the 50 states have mandated laws. These laws do vary in context and language from state to state but in all cases are part of the educational codes.

The decision to rule out education under the Basic Program did leave us with a complex problem. Proper treatment of many emotionally disturbed children and adolescents had to include some education. In fact, Residential Treatment Programs for emotionally disturbed children available in the United States range in program philosophy and context from private schools to adolescent treatment units of psychiatric hospitals.

There are no generally accepted standards for these programs nor do many states attempt to regulate their operation. In an effort to insure quality services for CHAMPUS beneficiaries in such institutions and to limit program coverage to medically-oriented programs, guidelines were issued on April 5, 1974, which would ultimately require psychiatric facilities serving children and adolescents to be accredited by the Joint Commission on the Accreditation of Hospitals (JCAH). Effective July 1, 1974, all such facilities wanting CHAMPUS coverage had to be either accredited by the JCAH or have applied to the JCAH for accreditation and meet CHAMPUS interim standards.

PSYCHOTHERAPY

The next major area which we feel needed better definition and control was psychotherapy. Costs attributable to psychotherapy had reached the point where they were approaching 20 per cent of the total expenditures under the program. Some of the reasons for this included the past broad and questionable interpretation of "treatment of mental conditions," the wide range of individual providers of care other than psychiatrists whose services were being cost-shared and the open-ended coverage being

To use the CHAMPUS program, the beneficiary goes to a civilian physician, hospital, or other authorized provider for care; identifies himself as a CHAMPUS beneficiary with his military-provided identification card; and obtains the authorized care he needs. The beneficiary should check first to learn if the provider of care he chooses will participate in CHAMPUS.

permitted. Many individuals were under long-term, continuous, intensive care for minor non-disabling character or personality disorders. Others who were, in fact, mentally or neurologically disabled and required care of a custodial type were being provided coverage for "active intensive psychotherapy."

The term "psychotherapy" itself is so broad as to defy definition. Almost every day we learn of new therapies being added to an already long list. Many are controversial and without clearly established validity. All therapies are expensive. One hour of therapy currently costs between $35 and $40. Many beneficiaries are receiving three or four hours of therapy per week extending for periods in excess of two years.

Faced with possible fiscal restrictions on the program by the House Appropriations Committee, we concluded that psychiatric care must be restricted in some way. Ideally, we needed professional guidelines as to what constitutes the essential elements of the practice of psychiatry so that overutilization, inadequacies of quality, inappropriate therapies and unreasonable costs could be subjected to scrutiny. Such guidelines were not readily available. The standard practice among other health insurance programs to control psychiatric costs was to limit the benefits or the dollars. After the review of limitations used by other programs and discussion of our problem with a group of psychiatrists, we established a limit of 120 inpatient days and 40 outpatient visits per fiscal year, effective July 1, 1974.

These limitations were immediately met with a great deal of objection. However, they have also facilitated productive discussions with the psychiatric community. Currently, we are engaged in discussions on psychiatric coverage under CHAMPUS with some 18 national associations representing various facets of the mental health field. The newly-formed American Psychiatric Association Commission on Standards of Practice and Third-Party Payment is working with us in our efforts to develop appropriate utilization controls.

The general willingness to cooperate with us has resulted in our removing the 120/40 limitations. Pending the development of a CHAMPUS-oriented program, we have directed that claims for psychotherapy care in excess of 120 days inpatient and 60 outpatient visits per fiscal year be evaluated under the same provisions as the High Option Government-wide Service Benefit Plan of the Federal Employees Health Benefits Program, Blue Cross-Blue Shield.

Claims for the psychiatric care of children and adolescents in residential treatment facilities in excess of 120 days will be subjected to professional review under the program we are presently developing with the help of the various associations and the National Institute of Mental Health.

Our goal for CHAMPUS is to eventually develop a uniform

Dependents residing with the active duty member usually must use a Uniformed Services medical facility for inpatient care if there is one available to them that can provide the required inpatient care. If the care needed is not available, the dependent will receive a non-availability statement indicating the fact and may then seek civilian care.

system of paying for the most appropriate type of care in the most economical setting for the minimal time required to achieve effective resolution of each psychiatric disorder.

PROGRAM FOR THE HANDICAPPED

The 1966 legislation contained special provisions for a particular class of individuals traditionally excluded by similar health insurance programs. I am referring to the provision which authorized financial assistance to pay for certain services required by the moderately or severely retarded and the seriously physically handicapped dependents of active duty members. These provisions were included because the active duty military member was frequently denied necessary services for his handicapped dependent because he was not a resident of the state in which he was stationed. Typically, when a member requested admission of his dependent to a state institution for the mentally retarded, blind, deaf, etc., he was required to prove that he was a legal resident. If unable to do so, he was denied services.

In many instances, the member would take the necessary steps which often included living in a state for a least a year, filing state income tax reports, and voting only to be placed on a waiting list. After several years of waiting out the list and finally getting his handicapped child in an appropriate program, he would be reassigned to some distant post. He then had another crisis to face—should he leave his child or take him to the new location and start the residency procedure all over again. Often individuals were forced to seek humanitarian discharges to avoid serious family problems due to the special demands of a mentally retarded or seriously physically handicapped dependent.

The purpose of the special provisions for the handicapped was to provide some financial assistance to the active duty member so that he could purchase the needed services from private, nonprofit providers when public resources were denied him. The dependents of retired members were excluded because upon retirement the member was no longer subject to military orders and could qualify as a resident of his state of choice.

The Program for the Handicapped has presented us with two problems. The law specifies that only the seriously physically handicapped be covered. The term "serious" has been subject to somewhat liberal interpretations as was indicated in earlier discussions of orthodontia. We have restricted the program by excluding those individuals who are classified as learning disabled but have no clinically-diagnosed mental or physical disabilty.

The second problem has to do with mentally disabled or retarded individuals who also have concomitant emotional and behavioral problems. In the past, these types of cases have been placed in long-term psychiatric programs under the Basic Program rather than under the Program for the Handicapped basically because the Basic Program offered a better financial benefit than the Program for the Handicapped. This may be contrary to the law because custodial and domiciliary care is prohibited under the Basic Program. We recognize the need for better definitions and guidelines in this area, and we are including this in our discussions with the psychiatric community.

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